

REGISTRATION FORM

			PAT	IENT I	NFORM	ATION					
Patient's last name:		F	irst:	M	liddle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Single		/ Div	/ Sep / Wid
Street address:					Date of E	Birth: (DD/MMI -	M/YYYY	Email A	ddress:		
Home phone no.:		City:				Provi	nce:		Post Co	de:	
Occupation:		Employer:	1 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Sand Service Service Services Services (Services)		Employ	er phone	e no.:	
Chose clinic because/Refe	erred to clin	ic by (places o	back one b	ων. Γ] Dr. 🔲	Chiroproctor	☐ Massag	o Thoronia)	- ~linia	[] Hespital
☐ Family ☐ Friend	······· · · · · · · · · · · · · · ·		Plaza		low Pages	Chiropractor		e Therapis □ Internet		Clinic	☐ Hospital
Other family members see		Location		Ш 10	low rages		reb Site _ [meme	. [
		RKERS CO	MPENS	ATION	(WSIB)	(ONLY IF	APPLIC	ABLE)	neria.		
☐ WSIB Injury		ccident: dd	/mm	/уу		laim Number:		walion was in Till	5IN#:		
Occupation:	En	nployer:	Employe	r address:				Employe	er phone	no.:	
								()	-	
Time off work?		Yes 🗌 No	How Lon	ıg?				Contact	at Work	:	
Description of Accident?											
Antonio como mante de la composició de la como della como de la co	O INSU	RANCE &			NFORM	ATION (O			ABLE))	
Date of Accident: dd	/mm	/yy ¬	Claim Nu				Adjuster				
Did you require medical at		Y	Did you r	equire an a	ambulance?	:	Did you l	nave x-ray	s?: ∐ \	ľ∐N	
Please indicate primary ins Subscriber's name:	surance:	Social Insura	nco No.	Birth date		Cvalle no .		Dollare			C
Subscriber's Harrie.		Social Insura		birtii date	. ,	Group no.:		Policy n	D.:		Co-payment:
Patient's relationship to su	hscriher:	☐ Self	Пя	pouse [/] Child	☐ Other					P
Name of secondary insura			Subscribe				Group no).:		Policy	/ no.:
Description of Accident:		The State of									
			CONSE	NT AND	VERIF:	CATION					
The above informatio directly to Active The insurer or WSIB in cir release any information I acknowledge and ag	rapeutic : cumstand on requir	Solutions. I ces whereby ed to proce	understa y the clair ss my cla	nd that I m has be ims to m	am finar en reject y insurer	ncially respo ed. I also a or the WSI	onsible for uthorize A [B.	any bal Active Th	ance n ierapei	ot pa utic S	aid by my Solutions to
consent to the full bi appointments are n	illing rat	e of that m	issed trea	atment s	ession. Ex	ktenuating (circumstai	nces are	exem	ot. M	
Patient/Guardian signat	ure						Date d	l d/mmm/yy	YY		



Date:	
Patient:	
Dr.	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

		and will	become part of y	our medical record.		
Name:	Last:	First:	Middle:	□M □F	DOB: / / dd/mmm/yyyy	Age:
Marital status:	Single	rtnered 🗌 Married	☐ Separated	☐ Divorced ☐ \	Widowed	
Family Doctor:				Date of last phys	sical exam:	
ype of Therapy W	anted:	Chiropractic Care	☐ Physio	/Rehab Therapy	☐ Unknown Le	et Dr. Decide
ype of Care Mana	gement:	Acute Relief Care	☐ Correc	tive Care	☐ Maintenance	/Supportive Care
		PE	RSONAL HEALT	H HISTORY		
urrent Compliant:						tan enter a consequent anticopina de una enter muse massa accesa anticasos en edicasos en
/hen did it occur?			1440-1111 1241 1241 1241 1241 1241 1241 1241 1241 1241 1241 1241 1241 1241 1241			
ave you had this efore?		the state of the s				
Vhat was the caus	e?					1000
/here do you feel i ne most?	it					
ggravations?						
ain at night?						
ssociated ymptoms?						
naracter of Pain:	☐ Sharp	☐ Constant		☐ Burning	☐ Improving	24111
	☐ Shootin	g 🗌 Intermittent		☐ Pins & Needles	☐ Worsening	
	☐ Ache	☐ Night Pain/Wa	kes from Sleep	☐ Numb	☐ Same since onset	
Please outline on the		DTR's: U		1 2 3 4 C	7 Left C5	C6 C7 L5 S1
our discomfort and						
				Vitals's: BP:	HR: W	T: TMP:



Date:	
Patient:	
Dr.	

Other D	octor's or Therapists	seen for this condition: Yes	☐ No Type of Treatment:	Results:
Has this	pain occurred before	a:		
	of Injury:	☐ Work Injury (WSIB)	☐ Auto Accident Injur	y Other
Surgerie				, Cale
Year	Reason	Эн 1800-жылын төр табар на төргөдөг на тараан т	a norma a tra con un fin de mai de parte en de mandra un sur un sente de la consecuención de consecuención de c	Hospital
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(Warried Committee Association		and the state of t	derbek is deuts is die bleide in een van de monten zers van van de een een van de een van van van de gezope ze	
Γests/X	-ray/MRI/CT/Ultra So	ound/Bone Scan/ Hospitalizati	ons	Lab/Hospital/Imaging Clinic
Year	Reason			Hospital/Lab/Imaging Clinic
		1940-1947 Copped (School of the Spirite Company of the Company of		

ist vour	prescribed drugs and	d over-the-counter drugs, such	as vitamins and inhalors	
lame the		Strength		equency Taken
er e	The Manufact Manufacture Control of the Control of		Name of the second seco	
			Proceedings (1990) and the state of the stat	
		Anna Contra de C		
llergies				
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	and the second s	HFAI TH HARITS	S AND PERSONAL SAFETY	
	4-20	· · · · · · · · · · · · · · · · · · ·	, I ENCOUNT ON ELL	



Date:	
Patient:	
Dr.	

Exercise	☐ Sedentary	(No exercise)							
	Sedentary (No exercise) Mild exercise (i.e., climb stairs, walk 3 blocks, golf) Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) Are you dieting?								
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf) Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.) Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.) Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.) Regular vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) Regular vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) Regular vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) Yes Yes								
	☐ Regular vi	gorous exercise (i.e., work o	r recreation 4x/week for 3	0 minutes)					***************************************
Diet	Are you dietin	g?					Yes		No
	If yes, are you	ı on a physician prescribed n	nedical diet?				Yes		No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola					
	# of cups/can	s per day?			and a file of the second field for the file of the file of the second file according to the second second file according to the second second file according to the second				
Alcohol	Do you drink a	alcohol?					Yes		No
	If yes, what ki	nd?						***************************************	
	How many dri	nks per week?			7 T T T T T T T T T T T T T T T T T T T				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Tobacco	Do you use to	bacco?					Yes		No
	☐ Cigarettes	– pks./day	☐ Chew - #/day	☐ Pipe - #/d	ay	☐ Cigars	- #/da	Э	
	# of years	☐ Or year quit				d			
Personal	Do you live ald	one?					Yes		No
Safety	Do you have f	requent falls?					Yes		No
	Do you have v	ision or hearing loss?			and the second s		Yes		No
		F/	AMILY HEALTH HIST	ORY	500 D.F. (1931-1931) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		2010/00/22 01 0 18310	601.00.000.000.00.00.00.00	
	######################################	CICNIEICANT HEALTH				***************************************		****************	
games 10 construction (10 construction (AGE				SIGNIFIC	ANT HEALTH	PROE	BLEMS	
Father			Children						
Mother				☐ M □ F					
Sibling	ПМ			□м					
	□ F □ M			☐ F	***************************************		***************************************		
	□ F			F	e andre a france a report of the second difference of the filled from 5 th 10 days ()		duen anne si con e	**********	
	□ M □ F		Grandmother Maternal						
	□ M □ F		Grandfather Maternal			15 V = 15 S S 16 M reg electric de conseque y 2%			
	□ M □ F		Grandmother Paternal						
	□ M □ F		Grandfather Paternal						
			MENTAL HEALTH	eritoroj er u monte unhaŭa dalikieri una urunen esso, emona u mana			ati kilojirisposki bajag skaja j	ares de la constanta de la cons	
Is stress a maj	or problem for you	?					Yes		۷o
Do you feel de	oressed?	MATERIAL PROPERTY OF THE STATE					Yes		No
Do you panic w	hen stressed?		ta tillianaan kan saata saata saa ta'a ka saa ka saa ka saa saa saa saa saa s				Yes		N o
Do you have tr	ouble sleeping?						Yes		Vo
			WOMPN ON T						
			WOMEN ONLY						1



Date:	
Patient:	
Dr.	

Number of pregnancies Numbe	r of live births			
Are you pregnant or breastfeeding?	J OI IIVE DILLIIS	ayan marajin marajiya maja ija marajin ya marajin a kalin jayan 17 kaya 18 ka 18 ka 19 ka 19 ka 19 ka 19 ka 19	☐ Yes ☐ No	
Any urinary tract, bladder, or kidney in	factions within the last 12 months?	оминичения по _{ст} ава на нападате, у подаращи у портова други у профессора постоя и подарателного.		
Any blood in your urine?	ections within the last 12 months:			
Any hot flashes or sweating at night?				
	oloating, irritability, or other symptoms at or ar	rand time of period?		
you have mensudal tension, pain, c	loating, initiability, of other symptoms at or ar	outly time of period?	☐ Yes ☐ No	
	MEN ONLY			
o you usually get up to urinate during	the night?		☐ Yes ☐ No	
f yes, # of times	-	у туу ч жинт түү туучин туну тоон м он оо оодоодоон ноодоод тоодоон тоосун тоосун тоосун оо оо оо оо оо оо оо	· · · · · · · · · · · · · · · · · · ·	
o you feel pain or burning with urinati	on?		☐ Yes ☐ No	
Any blood in your urine?				
	rostate infections within the last 12 months?		☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ No☐ No☐ No☐ No☐ No☐ No☐ No☐ No☐ N	
ate of last prostate and rectal exam?				
MANUARIA BARA SARA MANUARIA M				
arahan taménaménanahan danggalang alamban danggalang ang ang ang ang ang ang ang ang ang	OTHER PROBLEM	S	and the second s	
heck if you have, or have had, any syr	mptoms in the following areas to a significant	degree and briefly explain.		
] Cough	☐ Deafness	☐ Pregnant Due Da	te:	
] Shortness of breath	☐ Vision Loss	☐ Neck Pain		
] Bronchitis	Loss of Sensation	☐ Upper Back Pain		
] Asthma	☐ Diabetes	☐ Mid-Back Pain		
] High Blood Pressure	☐ Epilepsy	☐ Shoulder Pain		
Low Blood Pressure	☐ Arthritis	☐ Arm Pain		
] Hx of Heart Attack	☐ Cancer	☐ Leg Pain		
] Hx of Stroke	☐ Osteoporosis	☐ Knee Pain	11 O P. (21 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
] Pace maker	☐ Hepatitis	☐ Elbow Pain		
] COAD	☐ Tuberculosis	☐ Ability to sleep		
] Skin Allergies/Irritations	☐ AIDS/HIV	☐ Other pain/discomfo	rt:	
] Psoriasis/Eczema	☐ SARS	☐ Other pain/discomfo	rt:	
1 Totalian Commission	G JAIO	Outer pain/discornic		

Extended Health Benefit Information

PRIMARY COVERAGE: Patient Name: _____ Date of Birth: _ DD/MM/YYYY Insurance Company: _____ Policy Holder Name: _____ Date of Birth: ____ DD/MM/YYYY Certificate/Contract ID: Plan Number: **SECONDARY COVERAGE:** Insurance Company: Policy Holder Name: _____ Date of Birth: ___ DD/MM/YYYY Plan Number: Certificate/Contract ID:_____ Coverage Amount of Coverage % Amount of Doctor **Deductible** Year coverage per coverage per Referral year visit Chiropractic **Physiotherapy** Massage Therapy **Orthotics** Health Spending Account Acupuncture Additional Orthotic Coverage Questions: Can the orthotics be dispensed by a chiropractor? YES NO Are there any other requirements? TYES \square NO If yes, please describe: